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ABSTRACT

Discussed is the multidisciplinary team centered approach to educating the learning disabled child. Topics explored include various aspects of learning disability as a symptom complex (especially hyperactivity), the roles of multidisciplinary team members (such as the psychologist and the parents), and four approaches to psychotherapy (including family and group therapy). (LS)

LEARNING DISABILITY:

A MULTIDISCIPLINARY TEAM APPROACH

BY

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Learning disability as used in this paper refers to a complex of symptoms which are manifest in different proportions and influence the learning and adjustment of pupils in school. The learning disabled pupil manifests soft signs of brain damage or minimal brain dysfunction, derived from genetic, biochemical, perinatal, postnatal, environmental factors and illnesses or injuries. Though most researchers and clinicians consensually agree on most of these as etiologic, there continues to be controversy concerning what is minimal brain damage, and, its causation of learning disabilities (1) (4) (5) (6) (7).

Despite their disagreements, their emphasis on a variety of relevant clear-cut evaluative procedures to define, plan for and implement rehabilitative programs for specific learning disabled pupils offers options to educators to reduce the waste of human potential and resource caused by the inhibitions and blocks to learning. The learning disabled youngster is potentially creative but needs a specific teaching-learning approach to free his inhibited creative energy, and, guide it into constructive, achieving ends. He is characterized by a level of intellectual development within the average range, erratic functioning on tests of intellectual ability and in school achievement. His condition may be characterized by deficits in perception, sensorimotor functioning, conception, memory, language, emotional tone, attentional and impulse control.

His reading ability generally lags behind his ability in other subject areas. Since each child is different constitutionally, each child reacts in his special way emotionally to the unfavorable social and academic experiences which confront him as a result of his deficiency in reading

ability. Children with learning disabilities may avoid reading, indulging in excessive day-dreaming activity; they may also be hypoactive. A large number of these children struggle to assert themselves and gain some semblance of outer control through over-activity and social curiosity. These children are often described as "uncontrollable", and "unteachable" within our typical school and classroom. At times, incorrectly so, their behavior is attributed to poor intellectual ability, even though psychological assessment has identified their average ability and learning potential that is not too disparate from that of many of their peers. The symptom of over-activity or hyper-activity, as it is most commonly referred to, is most characteristic of the learning disabled pupil in school.

Determination of Aspects of the Youngster's Development

It is important to determine and differentiate aspects of the pupil's learning disability if relevant educative and rehabilitative efforts are to be effective. This diagnostic task is often accomplished by a psychological and/or neuro-psychiatric evaluation, which provides information about those developmental processes of the learning disabled pupil which are adaptive, and, those which are not.

Psychological tests help to uncover uneven development frequently. Erratic functioning, failing on easier questions requiring recall of recently or remotely presented information, or on tasks which require manipulation of objects, inability to reproduce a visual per-

cept in graphic form; or confusion of figure and ground on the intellective and manipulative aspects of the tests, are likely to be revealed. The latter help to uncover the origins of processes that result in the facilitation of some preferred functions, to the exclusion or impeding, of others. Not unusual in the youngster with a learning disability is his hyperactivity which alerts us to his need for a special learning environment. The recency or longstanding nature of his hyperactivity is important to uncover, when planning for his education and rehabilitation. At times what may be identified as hyperactivity may stem from a difference in tempo of the teacher and the characteristic motor activity of the specific child.

Hyperactivity is one mode of tension discharge which is characterized by persistent or active locomotion; its symptoms may occur in infancy, or during the period of ego differentiation and individuation, when the child's inquisitive and exploratory drives bring him into conflict with the expectations of his parents. Generally, the main parent is the mother, who until now could readily meet his more passive needs for nurturance, but with the emergence of his active use of his perceptual and locomotor systems, finds it very difficult to accommodate to the demands underlying his intrusive behavior.

At times hyperactivity may represent an overcompensation for a formerly immobilizing injury or illness, or, a defense against passivity or anxiety. Some youngsters need to be active to experience themselves as intact--as "being". Some hyperactivity is likely to have its origin in the genetic or neurological substrate of the individual; it could be a hereditary trait or

symptom of neurological deficit. Frequently these children are referred to as hyperkinetic.

Many youngsters with learning disability seek more tension reduction than their peers. The tension they experience may also be related to emotional conflicts; these may derive from unresolved dependency or troublesome aggressive feelings. The unresolved conflicts and preoccupations, which are below their level of awareness, exacerbate their disability, as they struggle in vain to keep the lid on burgeoning impulses that seek release. These could emerge as psychosexual fixations. Often, these determine how the youngster thinks about and approaches many situations, including learning and adapting to his social milieu. In some learning disabled youngsters a piecemeal or concrete form of learning is preferred to that requiring an assimilation of the totality or abstractness of the learning task. These youngsters often are described as "slow", "distractable", "having brief attention spans". They are the youngsters who walk around, play, talk or tell jokes when the situation requires work, and attentive participation. They need what they need immediately. (2) Their level of functioning frequently can be equated with that of their earlier orally dependent level of development, suggesting that they have not progressed past, or are fixated at this earlier level of development. Their response to learning and education is often characterized by tackling parts of a problem, infrequent completion of, and/or incompleteness of assignments, and avoidance of responsiblity for their actions. These behaviors generally render them incompetent in confronting the totality of an experience or a concept.

There are other learning disabled youngsters who ruminate over the minutest detail, on a clinging retentive level; these are hypoactive, or reflective; still others, who reflexively respond or react in an irrelevant, confused or disorganized manner. The impulse ridden youngsters relate in a reflexive fashion; immediate gratification is generally the goal. Cognitive abilities lag in development therefore. As a result of the inhibitions in cognitive functioning that arise from these conditions, learning for these youngsters proceeds at a slower, more difficult, erratic pace. They are often prematurely ready for, or not accessible to, learning at the time when attending, concentrating and comprehending are the objectives.

UNDERSTANDING AND AMELIORATING THE LEARNING DISABLED CHILD

The multidisciplinary team (3) which includes his teacher, school psychologist, physician, parent and other specialists who have knowledge about the individual pupil's adjustment difficulties, serves as a most functional method of collaborative resolution and remediation of the pupil's adaptational efforts. Through this team approach many aspects of the whole child are available for observation, and management; the psychologist provides a developmental, cognitive and behavioral map of the pupil initially. He initiates through his understanding of the pupil from essential differential diagnostic studies, suggestions of relevant teaching methods and media, from which the pupil's school and teacher can choose to enhance his adaptation and growth. Consultation with the pupil's physican and/or neuro-psychiatrist helps

refine and channel suggested developmental and remedial learning approaches with minimal waste of time, and pupil frustration. The inclusion of the neuro-psychiatrist in the educational rehabilitation of learning disabled pupils is essential to an affective multidisciplinary team approach. He may reecommend or prescribe stimulants or tranquilizers to facilitate the impulse control and learning of the learning disabled pupil.

The pupil's teacher provides information concerning his achievement, response to competition and academic tasks within or outside of the classroom. Her daily contact with him during the stressful and competitive learning periods at school or play with peers, helps to define the levels of his adjustment efforts. The teacher can pinpoint variations in his functioning from day to day in the areas of perceptual, sensorimotor, affective and cognitive functioning. His levels of tolerance for frustration, failure, ambiguity and warmth are readily discernible to her.

An effective team approach need not have all members in attendance to implement or modify its approach to the pupil's education. The freedom of communication between the disciplines, their respect for their individual roles, and the focus on pooling their resources to ameliorate the pupil's learning disability, increase the chances of successfully accomplishing the goal. The relationship of the professional team members with the administration of the school cannot be too highly stressed. The successful coordination of the team function depends on the openness of the administration, and its expression of clear-

cut differentiation of its goals, specifications of the roles of personnel and of limitations in its facilities. When the Whole Child is viewed as a functional unit rather than as a concept, all school personnel can more effectively accomplish their goal of meeting the learning needs of pupils, through sharing with, and learning from, other professionals within and outside of the school, pertaining to the pupil's adjustment.

THE ROLE OF THE PARENTS--AN INDISPENSABLE ONE

The parent membership in the team is a very significant one. The best laid plans of psychologists, educators and others can be sabotaged when the parent's understanding and support are not forthcoming. Parents are primary reinforcing agents of behavior. They can help facilitate new learning and ways of relating. The encouragement to succeed, the stimulation to be a more lovable and effective person, feelings of acceptance and recognition, emanate from parents. Despite groups which lobby for and support educational programs for the learning disabled or handicapped child, what is needed is the human warmth, concern, support, and active participation of the parent, for the child and his therapeutic education. The frustration parents experience in seeing their offspring, capable, yet, unable to function effectively, often mobilizes feelings of helplessness and anger in the parents. Often they seek relief through projection of blame that is inappropriate. The educational system, the teacher, the child, someone else is often blamed in their impatience and anger, concerning their youngster's condition. Pressure to accomplish at a faster rate, demands on the

youngster, far above his level of cognitive readiness, or emotional maturity are likely to be made.

Team membership brings the parent into the alliance for a more systematic approach to accomplishing many of their goals, which frequently are consonant with those of the pupil and educational staff. The communication feedback process, that is set in gear, assures that parents will only intervene when they have optimal knowledge of the timing, sequencing and purposefulness of their intervention, and that such intervention is consistent with considered educational and rehabilitational plans. Of course, there are always those parents who give up responsibility to the school or refuse to participate in their child's behalf; frequently this increases the difficulty of the rehabilitative task. It is not unusual to find that the emotional demands made on parent and youngster make it necessary for both to undergo psychotherapy. For the parent this provides guidance and support; for the pupil, this may serve both to bolster his ego, give him opportunities for release of tension, and provide avenues for alternate means of learning and relating emotionally. The psychotherapist rather than being an anonymous worker, becomes an active member of the team.

THE PSYCHOTHERAPIST - CHILD - PARENT INTERACTION

Psychotherapy provides emotional education and re-education for the parent and child. Several approaches to foster more positive emotional attitudes and relations are available, including:

1. Individual Therapy: the pupil meets alone with his therapist to express and learn to channel feelings in more positive ways.

2. Family Therapy: parents, pupil and significant family members - including siblings meet with the therapist. Family therapy opens up opportunities to more fully explore the appropriateness of any member of the family's behavior, their role perception and functioning within the feedback, relational system of the family. The family's behavior as a social structure is also actively explored during the sessions to determine its viability, relevancy and appropriateness to the welfare of all family members, including the learning disabled pupil. Learning of new roles or modification of old ones or behaviors is one of the growth promoting experiences which help to enhance learning and adjustment of the learning disabled.

3. Group Therapy: the pupil meets with 7 to 9 youngsters who are within his developmental and age range, to explore feelings and ways of relating appropriately with a trained group therapist. The sharing of feelings concerning his achievement and social group membership at school frequently releases new or alternative ways of reacting, feeling and

functioning as a result of the feedback provided by the group experience.

4. Parent Counseling Groups: parents meet in a group of 10 to 12 other parents of youngsters with similar or related learning and adjustment problems, to develop their understanding, mutually experience, share and learn new and alternate ways of relating to their youngster, so as to enhance his positive adjustment, on an academic, social and emotional level.

These therapeutic services are provided by competent mental health practitioners or private, municipally or church affiliated counseling or psychotherapy centers. With their concern for their client, - the learning disabled pupil, the therapists and/or agencies become active members of the multidisciplinary team. They enhance the educational and social rehabilitational efforts without disrupting the confidentiality of the therapist/client contract.

The efficiency of the team approach, lastly, though not of least importance depends upon the development of a specific and common language to describe each unique learning disabled pupil, his comprehension, various abilities, skills and levels of emotional and social development. Similarly, prescriptive modes of teaching or relating to the pupil, which are varied, yet relevant and defined through behavioral operations become most helpful in facilitating the placement, remediation, progressive evaluation and followup of the pupil.

In summary, this paper explored the multi-disciplinary team centered approach to educating the learning disabled youngster for academic, emotional and social competence. Various aspects of learning disability as a symptom complex were delineated, in terms of the initial determination of the developmental process that contributed to the learning disability. The complementary roles of team members including pediatrician, neurologist, mental health consultant, educator, other related specialists, parent and youngster were indicated. Active support, communication and feedback, clear delineation of roles, skilled contributions and followup by all members were emphasized as essential to the amelioration of the pupil's learning disability. As a result, the emotional stress that both he and his parents experience could be resolved.

The role of emotional education and re-education, to foster more effective interpersonal relationships through a variety of therapeutic efforts was also presented. The role of medication was only cursorily mentioned. In general the author considers this whole child approach to be one of the most effective ways in which a multi-disciplinary team can meet the special educational needs of the learning disabled.

Underlying it all is his belief in the modifiability to varying levels of the adjustment of all human beings, providing there is a consistent, well founded program and adequate follow through, and feedback between all "team" members in a relatively easily communicated and understood manner. The eventual result is a more self-actualized contributing member of society, who otherwise would never have achieved a sense of positive ego worth.

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